

Instructions for Completing the Central Billing Office Application

These directions are not meant to take the place of the reference pages enclosed with the Central Billing Office application. The intention is to provide supplemental information to assist you in completing the applications forms correctly. Please note that the reverse sides of all original forms print out as a second page. Provider Connections is not responsible for the accuracy of your CBO application if you fail to follow these instructions.

*** Please note that the new HIPAA format requires the use of 9-digit zip codes on all CBO forms. ***

The Payee Agreement:

The Payee Agreement replaces the former Individual and Agency Service Provider Agreements. Only one copy of the Payee Agreement needs to be completed by an agency. All subsequent agency applicants should disregard the Payee Agreement portion of the CBO application.

- Your name must match the name on your state license on all application forms.
- Enclose a copy of your marriage license or other court document if your name is different.
- “Payee name” refers to the individual provider’s name or the agency name.
- The “Payee Representative Name” is the individual provider or person acting as the Agency Representative.
- “Title” refers to the title of the Agency Representative signing the agreement. Individual providers should write “Individual” on this line.
- The individual provider or agency representative must sign and date this page.
- Be sure to return all six of the pages. This is an agreement between you and the Illinois Department of Human Services so all six pages of the Payee Agreement are required.
- Only Interpreters and Deaf Mentors need to complete the Addendum to the Payee Agreement. Other applicants should disregard this page as it does not apply.

The EI Service Matrix:

Provider Connections sends this page to the Central Billing Office along with the W-9 Form. Enclosed with the application is a list of county codes—be sure to use the codes and not the county names. File the county code sheet for future reference. “How to contact you for referrals” should be used as a site of service address for agency providers. Individual providers should list their contact address in this space. Refer to the Matrix Instructions to complete this page.

Important to note: as of May 1, 2007, all applicants must have their own personal NPI (National Provider Identification) number. **Applications missing the NPI number cannot be processed.** You can obtain one by going to <http://nppes.cms.hhs.gov>.

Initial Interpreter applicants must document completion of Systems Overview Training, Interpreter Training, and successful score on the Interpreter/Translator proficiency exam. A Transportation applicant must include a photocopy of his/her driver’s license, proof of insurance, and vehicle registration with the enrollment application. Applications cannot be processed without such documentation.

Indicate the insurance companies you are enrolled for as a provider. If you are not enrolled with any, leave this part blank.

The Provider Enrollment Application (HFS 2243):

EI providers need to complete only Sections A, B, and F on this form. Do not complete any other sections. Please note that highlighting is forbidden on any HFS documents.

Section A: Only #1-15 need to be completed. All else does not apply.

- If you are an agency provider you must list both your full social security number and the agency FEIN number.
- Refer to Attachment A to get the code for #2 Provider Type.
- Even though it asks for an “Office Address” HFS prefers you use a home address where you can be reached for re-enrollment mailings every three years. Be sure to use a street address—Post Office box numbers are not acceptable on this page.

Section B: Refer to Attachment A to get the code for #22 Category of Service. This is the only blank you need to complete for Section B.

Section F: Sign, date and print your name in this section.

The Agreement for Participation in the Illinois Medical Assistance Program (HFS 1413):

On the front side of the form, list your name, and if you are a sole proprietor, you should list your d.b.a name. Do not list your corporate agency name as a d.b.a. unless you own the company. If you are already enrolled with the HFS and have an HFS provider number, list it on the line below your name. Do not list your agency’s HFS or FEIN number on this line.

On the reverse side of the form, complete #14 only if you are an owner or a stockholder in the agency. If you are an independent provider, you must write “NONE” on the Print Name line. Sign, date, and print your name. Leave the agreement effective date blank. Do not highlight any portion of this form.

The Enrollment Disclosure Statement (HFS 1513):

This form is a new addition to the Central Billing Office enrollment application, effective March 1, 2010. This form requires a provider’s individual information, and should not include any specific agency information.

Under Section 1, list your name and home address information and telephone number along with your NPI number and HFS Provider number if you have one. If you do not, write in “None.”

Under Section 2 (a) and (b) write “None.” In Section 2 (c) check “Other,” and write in “Individual” or “Working for a [write in the appropriate entity]”. Then write “None” on the name line below. On Section 2 (d) check the “No” box.

On Section 3, check the “No” box. On Sections 4 and 5, write “None” on the Name line or the name(s) of offending individuals. At the bottom where it asks for “Name of Authorized Representative” print your name and write “Individual” on the Title line. Then sign it and date it.

The W-9 Request for Taxpayer Identification Number and Certification:

IMPORTANT: This page must be completed correctly or the entire application will be returned to you. Only the applicant or applicant’s agency is authorized to make corrections to this page.

If you are an agency provider, your personal name does not go on this form. Print the agency name in the “Name” blank. If the agency is using a d.b.a., that name should be listed using the prefix d.b.a. on the “Business name” blank. Check the appropriate tax status box. Enter only the agency FEIN number for the tax identification number in Part I. Do not list your social security number. A signature and date is required on Part II—either an agency representative or a provider signature is acceptable.

If you are an owner of sole proprietorship or a disregarded entity LLC, place your personal name on the “Name” blank and “d.b.a. Your Business Name” on the Business name blank. Check the appropriate box. Enter the address information. If you have a FEIN number, list both your social security number and your FEIN number in Part I. Your signature and date is required in the specified blanks in Part II. Your name and signature must match the name on your state license.

If you are an individual, enter your name on the “Name” blank. Skip the business blank or write in parentheses “Private.” Enter your address information, check the individual/owner of sole proprietorship box, and enter your social security number in Part I. Sign and date the specified blanks in Part II. Your name and signature must match exactly, and they must match the name on your state license.

Any W9 Form with a date more than two years old is invalid and cannot be processed.

Attach a copy of your current state license to this application. The only exceptions are professions, which are not required to have a state license [e.g., Developmental Therapists].

Parent Liaisons, Deaf Mentors, and Interpreters are not enrolled with the Department of Healthcare and Family Services and should not complete HFS 2243, 1413, or 1513. These providers should send only the Payee Agreement (if applicable), the EI Service Matrix, and the W-9 form.

VERY IMPORTANT: ALL SIGNATURES ON THE CENTRAL BILLING OFFICE APPLICATION PAGES MUST BE ORIGINAL. REPRODUCED SIGNATURES OF ANY KIND ARE INVALID AND WILL CAUSE THE APPLICATION TO BE RETURNED.

Important to Note

Provider Connections recommends using the most recent applications. It is best to download applications directly from the Provider Connections website and avoid maintaining a stockpile of file copies. Forms change and become obsolete, and obsolete forms are invalid.

**Illinois Department of Human Services
Payee Agreement for Authorization to Provide Early Intervention Services**

Note: The Payee shall type or print legibly all information except for the signature.

The Payee Agreement is for the sole use of an entity, which either employs or contracts with Early Intervention Providers, to provide Early Intervention Services or for the sole use of an entity that enrolls as an Independent with no employees, whichever is applicable.

This Early Intervention Payee Agreement is entered into by and between the Illinois Department of Human Services (DHS) as the Lead Agency for the Illinois Early Intervention Services System and funder of the Early Intervention Program, (EI), and:

(Payee Name)

Purpose of Agreement: The purpose of this Agreement is to establish the duties, expectations and relationship between DHS and the Payee who is certified by the State of Illinois Comptroller to receive payment from the DHSCBO and who makes service(s) available to eligible children and their families according to the Illinois Early Intervention Services System Act 325 ILCS 20/5 et. seq. (the Act); Part C of the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. Section 1431 et seq.); the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Family Educational Rights to Privacy Act (FERPA) and its rules, 34 CFR 99; and EI administrative rules, 89 Illinois Administrative Code 500 (Rule 500).

Definition of Payee: The Payee is the entity identified on the W-9 page of the Central Billing Office Enrollment Application under Business Name and Taxpayer Identification Number. The Payee may be an entity who employs providers or an independent with no employees (Payee as named above).

Definition of Provider: A person that actually provides Early Intervention services to children and families. This includes Physicians, Optometrists, Audiologists, Therapists, Counselors, Parent Liaisons, Deaf Mentors, Interpreters, Nurses, Nutritionists, Transportation and Assistive Technology services.

Definition of Child and Family Connections (CFC): The CFC is the system point of entry in a designated geographic region that is responsible for providing access to the Illinois Part C Early Intervention Services System, for providing service coordination services, and for maintaining the child's permanent EI Record for referred and eligible children.

Definition of Department of Human Services Central Billing Office (DHSCBO): The DHSCBO is an entity designated by DHS for the processing of Early Intervention claims and for data collection.

In consideration of the Authorization to Bill DHS for the Provision of Services, the Payee Shall:

1. Not bill families directly for authorized early intervention services. (See #'s 6 and 7 for more information).
2. Provide only those services for which the Payee has a written authorization **in hand**. The exception to this rule is the IFSP meeting. Providers will receive authorization for this meeting based upon actual attendance.
3. Verify insurance company coverage of benefits and comply with insurance company requirements, including network enrollment and documentation requests as outlined in DHS policy, unless insurance use has been waived or exempted by the Department or is a service provided at public expense. (See #6 for services provided at public expense).

Bill private insurance before submitting claims to the DHSCBO for covered services for all Early Intervention (EI) children **unless** an insurance exemption or pre-billing waiver has been issued **or** the service is provided at public expense.

Within 90 days of receipt of the insurance Explanation of Benefits (EOB), submit claims to the DHSCBO with the EOB attached. The EOB and a completed claim shall be submitted to the DHSCBO for all EI children **even if the entire claim was paid by private insurance**.

Understand that a CFC cannot generate/backdate an insurance waiver or exemption that would apply toward dates of service that have been previously provided to the child/family. Accepting waivers or exemptions post service delivery is not allowed under EI policy.

4. Submit claims to the DHSCBO at the Payee's usual and customary rates.
5. Accept the EI rates as payment in full for covered services provided unless this rate is exceeded by the insurance payment. If the insurance payment is less than the EI rate, then the DHSCBO should be billed for the difference. An Explanation of Benefits from the insurance company shall be submitted with the claim to the DHSCBO.

Submit legible claims to the DHSCBO on the CMS 1500 form, UB04 form, and for transportation on the DHSCBO Billing Form, or an exact electronic facsimile of one of these forms. Claim information must be **typed or submitted through electronic transfer**.

Submit claims to the DHSCBO for IFSP Development only as defined in the Provider Handbook entitled *Early Intervention Service Descriptions, Billing Codes and Rates*.

Not bill or accept reimbursement from the DHSCBO for services in excess of what has been authorized and identified on the child's IFSP. The Payee shall be fully liable for the truth, accuracy and completeness of all claims submitted to the DHSCBO for payment. Any submittals of false or fraudulent claims or concealment of a material fact may be prosecuted under applicable Federal and State laws.

Submit to the DHSCBO an invoice of charges for services **no later than 90 days** following the service delivery date **or** the receipt of the insurance EOB. Claims **must** indicate the specific individual who actually provided the services or the associate who actually provided the services and his/her credentialed supervisor under whom the authorization was billed against.

Resubmit a claim no less than sixty (60) calendar days from the original submission date of the claim. The resubmitted claim shall be stamped or otherwise marked to delineate that it is a **"RESUBMISSION"** or **"STATEMENT OF ACCOUNT"** and shall include only services documented on the original claim.

6. Not bill the family directly or their insurance for screening, evaluation and assessment services, IFSP development, or implementation of procedural safeguards, as delineated in 34 CFR 303.170 et. seq., since these services **must be** provided at public expense. However, the Payee may bill the DHSCBO for evaluation and assessment and IFSP development services.
7. Not bill the family directly for direct services unless the insurance **payment was paid to the family versus the payee and the payee has a copy of the signed "Child and Family Connections Insurance Affidavit, Assignment and Release" form in hand**. Accept the insurance payment as payment in full unless the payment is less than the EI Rate. (See #5).
8. Participate in evaluation/assessment activities and the development, review and revision of each child's IFSP as set forth in 34 CFR Part 303, and current DHS directives as delineated in writing, including the "Principles of Early Intervention". Except for associate level speech language

pathologists who are completing a supervised professional experience, associate level providers do not participate in evaluation/assessment activities for review or revision of the IFSP.

9. Provide a report of findings to each child's service coordinator **in a format designated by DHS** that describes the tests/methods used in evaluation/assessment activities, the results of the test/method including a score and a typed narrative interpretation of the results.
10. Submit all evaluation/assessment reports to the service coordinator within 14 calendar days of receipt of the request to perform evaluation/assessment.
11. Provide a direct service report to each child's service coordinator **in a format designated by DHS** for each six (6) month IFSP review, or more often if the child's progress or lack of progress warrants a review.
12. Provide originals of evaluation/assessment reports and documents created on behalf of early intervention such as direct service reports required for the six-month review, discharge reports, written justification of need statements and letters of developmental necessity for Assistive Technology services to the child's assigned Service Coordinator. The Payee shall also keep copies as part of the child's record.
13. Provide appropriate service(s) as set forth in the IFSP, to eligible children and their families upon referral and in accordance with pertinent rules, DHS directives, and frequency, intensity and duration timelines identified in the IFSP and on the authorization.
14. Notify the child's Service Coordinator of any recommended changes in the delivery of services prior to implementation of changes, to ensure that modifications to an existing IFSP are made through the appropriate DHS procedure.
15. Not terminate services for an eligible child without written notification to the child's service coordinator and family at least 30 days prior to the anticipated date of service termination.
16. Meet and maintain all applicable standards and regulations for staff and Payee licensure, certification and credentialing. Hire staff to provide services to children and their families who meet the State's professional licensing standards and EI credentialing requirements and ensure that all staff performing services under this agreement has the skills to work with the children they serve and hold appropriate EI credentials prior to providing services.
17. Comply with all applicable laws and regulations for physical facilities in which services are made available.
18. Maintain accurate records, including daily documentation of services for each date of service billed, including IFSP development time, for a period of at least six years from the child's completion of EI services, and permit access to these records by the local CFC, DHS, or if they are Medicaid reimbursable services, the Illinois Department of Healthcare and Family Services (HFS) and the Centers for Medicare/Medicaid Services (CMS), or the United States Department of Education. In the absence of proper and complete documentation, no payments will be made and payments previously made will be recouped by DHS or HFS.

If there are outstanding audit exceptions, records shall be retained until such exceptions are closed out to the satisfaction of DHS. If there is active or pending legal action, records shall be retained until a final written resolution is achieved. The Payee/Provider shall also be available, as required, for mediation, impartial administrative proceedings and/or other legal proceedings.

19. Complete the Medicaid enrollment application and bill the DHSCBO for covered services provided to Medicaid eligible children.

20. Provide routine monitoring and supervision activities as set forth by state licensure requirements and delineated in writing by DHS, including self-assessment, on-site monitoring, data collection and reporting obligation, record or chart audits, financial audits, complaint investigation, and consumer satisfaction surveys. Understand that these are administrative functions that are not billable to the DHSCBO.
21. Follow Part C federal laws and regulations and state laws, policies, guidelines, directives and procedures regarding Early Intervention services and other laws and regulations applicable to Payee's and providers hereunder (Example: State licensure laws).
22. Provide services and communications to clients in a language or mode of communication understood by the child/family. If the Provider is unable to provide services and communications to the clients in a language or mode of communication understood by the child/family, the Payee shall notify the CFC.
23. Inform eligible families of their rights and procedural safeguards, including mediation and impartial administrative proceedings as delineated in 34 CFR 303.170 et. seq. and in Rule 500, and comply with those rights, and procedural safeguards.
24. Maintain liability insurance sufficient to cover any potential liability such as loss, damage, cost or expenses, including attorney's fees, arising from any act or negligence of the Payee or its employees/contractors.
25. Accept all children eligible for Early Intervention services without discrimination, including but not limited to children with public or private insurance.
26. Provide staff to participate in each EI IFSP Development meeting as a billable activity as specified in Illinois administrative rules for EI and 34 CFR Part 303.343 et. seq. Participation in IFSP meetings and periodic reviews is required.
27. Have access to the Internet, and monitor the Early Intervention/Provider Connections websites on a **weekly** basis for changes and/or updates that affect the functions of the Early Intervention system.
28. Comply with all applicable Federal and State laws, including the American Recovery and Reinvestment Act of 2009 and its reporting requirements.
29. Comply with HIPAA Standards 45 CFR Parts 160, 162 and 164 and any additional parts that may be finalized in the future, where applicable.
30. Not use or disclose protected health information except as allowed by the HIPAA Standard 45 CFR Parts 160 and 164 and not use or disclose EI records except as allowed by FERPA.
31. By signing this agreement, the Payee certifies that each employee providing EI services has:
 1. not been delinquent in paying a child support order as specified in Section 10-65 of the Illinois Administrative Procedure Act [5 ILCS 100/10-65];
 2. not been in default of an educational loan in accordance with Section 2 of the Education Loan Default Act [5 ILCS 385/2];
 3. not served or completed a sentence for a conviction of any of the felonies set forth in 225 ILCS 46/25(a) and (b) within the preceding five years (see 30 ILCS 500/50-10);
 4. not been indicated as a perpetrator of child abuse or neglect in an investigation by Illinois or another state for at least the previous five years; and
 5. been in compliance with pertinent laws, rules, and government directives regarding the delivery of services for which they seek credentialing.

In consideration of the performance of this Agreement, DHS shall:

1. Produce authorizations in the name of the Payee only and not in the name of any individual staff employed or contracted by the Payee for services to be performed by the Payee.
2. Notify the Payee, a reasonable time in advance of implementation of any changes in rules regulations, procedures, policies, directives and any other program guidelines that affect the Payee's performance of this Agreement. This notification may be via the DHS Early Intervention/Provider Connections Websites. Copies of DHS rules, policies, guidelines, directives, etc., can be obtained from the DHS Early Intervention Website (www.dhs.state.il.us/ei) or the Provider Connections Website (www.wiu.edu/providerconnections).
3. Reimburse the Payee for services rendered under this Agreement pursuant to the rates established for the covered services provided and only for those services pre-authorized in the IFSP. DHS shall adjust future payment to a Payee that has been underpaid or offset payment to a Payee that has been overpaid.
4. Comply with HIPAA Standards 45 CFR Parts 160, 162 and 164 and any additional parts that may be finalized in the future, where applicable.

Termination of this Agreement: This agreement may be terminated by either party, in writing, without cause, with at least thirty (30) calendar days' prior written notice. This Agreement may be terminated by DHS at any time for failure by the Payee to perform any of the obligations and provisions set forth in this Agreement. This termination will be in writing, by DHS, and will specify the termination date.

Confidentiality: All records and other information obtained by the Payee concerning persons served under this Agreement are confidential pursuant to State and Federal statutes, Federal regulations and DHS administrative rules and shall be protected by the Payee and employee's of the Payee from unauthorized disclosure.

Liability: DHS assumes no liability for actions of the Payee or its employee's under this Agreement. The Payee agrees to indemnify, hold harmless and defend DHS against any and all liability, loss, damage, costs or expenses including attorney's fees arising from intentional torts or any act or negligence of the Payee or its employees, with the exception of acts performed in conformance with an explicit, written directive of DHS. The Payee agrees to maintain liability insurance sufficient to cover any potential liability.

Right of Audit and Monitoring: DHS maintains the right to inspect and audit any or all information or records in possession of the Payee/Provider that pertain to this Agreement. This right to audit extends to pertinent State and Federal officials, including the Department of Human Services, the Department of Healthcare and Family Services, federal auditors and the Office of the Auditor General of Illinois.

Void: This Agreement shall become null and void on the date that the Payee/Provider ceases to participate in the Department of Healthcare and Family Services Medicaid vendor program or provides at least a thirty (30) calendar days' prior written notice to terminate.

Miscellaneous: This Agreement may be executed in any number of counterparts, each of which shall be deemed an original. All paragraph headings are for referral purposes only and shall not in any way affect the meaning or interpretation of this Agreement. Failure of DHS to enforce any provision of this Agreement shall not constitute a waiver of that provision by DHS.

Entire Agreement: DHS and the Payee understand and agree that this Agreement constitutes the entire agreement between them and that no promises, terms, or conditions not recited herein or incorporated herein or referenced herein, including prior agreements or oral discussions, shall be binding upon either the Payee or DHS.

Laws of Illinois: This Agreement shall be governed and construed in accordance with the laws of the State of Illinois and all subsequent amendments.

Notice: Notices under this Agreement regarding termination will be in writing and will be deemed to have been given when delivered by hand, U.S. Postal Service, messenger service, or overnight delivery service to the address listed on the following page or such other address as DHS shall specify in a written notice to the Payee or post on the DHS Website (www.dhs.state.il.us/ei).

DEPARTMENT OF HUMAN SERVICES:

PAYEE INFORMATION: (Please mail your completed application/ agreement to Provider Connections.)

Name: Janet D. Gully

Payee Name: _____

Title: Chief, Bureau of Early Intervention

Payee Rep. Name: _____

Address: 222 S. College, 2nd Floor

Title: _____

Springfield, IL 62704

Address: _____

Please mail your completed application/agreement to:

City: _____

Provider Connections
Western Illinois University
c/o Center for Best Practices in Early Childhood
1 University Circle
Macomb, IL 61455

State, Zip Code: _____

Phone #: _____

Payee Tax ID #: _____

Taxpayer Certification: Under penalties of perjury, the Payee representative certifies that the Payee's Social Security Number or Federal Taxpayer Identification Number (FEIN) is correct. The entity identified as the "Payee" is doing business as:

- Individual
- Corporation NOT providing or billing medical and/or health care services
- Owner of Sole Proprietorship
- Trust or Estate
- Partnership
- Foreign corporation, partnership or estate
- Tax-exempt hospital or extended care facility or trust
- Not-for-Profit Corporation
- Government Entity
- Other: _____
- Corporation providing or billing medical and/or health care services

Severability: If any provision of this Agreement is declared invalid, its other provisions shall not be affected thereby.

Signature Authority/Execution: The signature of all who sign this Agreement on behalf of the Payee and DHS are required for Execution of this Agreement. Each signature has been made with complete and full authority to commit the party to all terms and conditions of this Agreement, including each and every representation, certification and warranty contained herein. This Agreement becomes effective the date the Secretary's signature is affixed to this Agreement.

Printed Name of Payee: _____

Printed Name of Payee Representative: _____

Payee Representative Signature: **X** _____ Date: _____

Illinois Department of Human Services

Printed Name: Grace Hong Duff, Acting Secretary

Signature: **X** _____ Date: _____

****FOR DHS USE ONLY****

EI Service Matrix

Individual Provider Name _____ (e.g. Adams, Jane)

Individual SS# _____ Individual NPI # (10 digits) _____
(last 4 digits only) (National Provider ID)

Organization/Payee Name _____

Phone Number _____ Fax Number: _____

Illinois Counties Served _____ (Used attached codes) Working Hours: _____

Early Intervention Services

- | | |
|--|---|
| <input type="checkbox"/> Assistive Technology | <input type="checkbox"/> Licensed Clinical Psychologist |
| <input type="checkbox"/> Audiology | <input type="checkbox"/> Certified School Psychologist |
| <input type="checkbox"/> Aural Rehabilitation | <input type="checkbox"/> Licensed Social Worker |
| <input type="checkbox"/> Developmental Evaluation (physicians only) | <input type="checkbox"/> Licensed Clinical Social Worker |
| <input type="checkbox"/> Nursing | <input type="checkbox"/> Certified School Social Worker |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Licensed Marriage/Family Therapist |
| <input type="checkbox"/> Consultation (physicians only) | <input type="checkbox"/> Licensed Regional Optometrist |
| <input type="checkbox"/> Licensed Occupational Therapist | <input type="checkbox"/> Developmental Therapist |
| <input type="checkbox"/> Licensed Physical Therapist | <input type="checkbox"/> Service Coordinator |
| <input type="checkbox"/> Licensed Speech/Language Pathologist | <input type="checkbox"/> Parent Liaison |
| <input type="checkbox"/> Board Certified Behavior Analyst | <input type="checkbox"/> Deaf Interpreter (certification also required & SO Training) |
| <input type="checkbox"/> Licensed Professional Counselor | <input type="checkbox"/> Bi-Lingual Interpreter |
| <input type="checkbox"/> Licensed Clinical Professional Counselor | (Proficiency Test, Interpreter Training & SO Training required) |
| <input type="checkbox"/> Transportation (Driver's License, Proof of insurance & Vehicle Registration Required) | _____ (Language) |
| | <input type="checkbox"/> Writing Proficient (Proficiency Test Required) |
| | <input type="checkbox"/> Speaking Proficient (Proficiency Test Required) |

Additional Services: _____

How to contact you for referrals: _____

Address (Street, City, Zip Code): _____

Services Provided: ___ Direct Services ___ Eval./Assmt. Service Locations: ___ Onsite ___ Offsite

Languages Other Than English: _____ DSCC Provider: ___ Yes ___ No

Insurance Companies Enrolled with as a Provider (updates to this information should be sent to the EI CBO Office):

(attach additional pages if necessary)

_____ Signature (Required)	_____ Date
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Illinois County Codes

001	Adams	027	Ford	053	Livingston	079	Randolph
002	Alexander	028	Franklin	054	Logan	080	Richland
003	Bond	029	Fulton	055	Macon	081	Rock Island
004	Boone	030	Gallatin	056	Macoupin	082	St. Clair
005	Brown	031	Greene	057	Madison	083	Saline
006	Bureau	032	Grundy	058	Marion	084	Sangamon
007	Calhoun	033	Hamilton	059	Marshall	085	Schuyler
008	Carroll	034	Hancock	060	Mason	086	Scott
009	Cass	035	Hardin	061	Massac	087	Shelby
010	Champaign	036	Henderson	062	McDonough	088	Stark
011	Christian	037	Henry	063	McHenry	089	Stephenson
012	Clark	038	Iroquois	064	McLean	090	Tazewell
013	Clay	039	Jackson	065	Menard	091	Union
014	Clinton	040	Jasper	066	Mercer	092	Vermilion
015	Coles	041	Jefferson	067	Monroe	093	Wabash
016	Cook	042	Jersey	068	Montgomery	094	Warren
017	Crawford	043	JoDaviess	069	Morgan	095	Washington
018	Cumberland	044	Johnson	070	Moultrie	096	Wayne
019	DeKalb	045	Kane	071	Ogle	097	White
020	Dewitt	046	Kankakee	072	Peoria	098	Whiteside
021	Douglas	047	Kendall	073	Perry	099	Will
022	DuPage	048	Knox	074	Piatt	100	Williamson
023	Edgar	049	Lake	075	Pike	101	Winnebago
024	Edwards	050	LaSalle	076	Pope	102	Woodford
025	Effingham	051	Lawrence	077	Pulaski	103	Unknown
026	Fayette	052	Lee	078	Putnam	104	Entire State

EARLY INTERVENTION SERVICE MATRIX INSTRUCTIONS

Direct Service:

Indicate if you provide EI services directly with an "X" or if you provide funding only with an "F". Leave blank if you do neither.

Evaluation/Assessment:

Indicate if you provide evaluations or assessments directly with an "X" or if you provide funding only with an "F". Leave blank if you do neither.

Onsite/Offsite Service Locations:

Indicate both whether or not you offer services onsite (the child comes to you) and whether or not you offer services offsite (you go to the child).

Individual Provider Name:

Indicate your name as you prefer it listed for billing purposes.

Organization Name:

Indicate your program/agency's name. If you are enrolling as an independent contractor, indicate "private."

Phone Number:

Indicate the main phone number where you will accept referrals. Additional phone numbers can be indicated in the "How to Contact You for Referrals" section.

Illinois Counties Served:

Using the code list attached, indicate all Illinois Counties that you serve.

Early Intervention Services

Indicate each type of early intervention service you provide directly with an "X" or fund only with an "F". If you have not yet applied for or received an EI credential to provide this service, you must apply for the appropriate credential.

Additional Services:

Indicate any non-EI services you provide directly with an "X" or fund only with an "F".

How to Contact You for Referrals:

Indicate how you accept referrals. If you work for multiple programs/agencies or also have a private practice, indicate referral instructions for each here, including phone numbers if different from the main phone number you listed in the first row.

Additional Information:

Indicate any other pertinent information here. If you have more than one mailing address, additional addresses can be listed here with instructions for their use.

Languages Other Than English:

Indicate any additional languages in which you are fluent.



PROVIDER ENROLLMENT APPLICATION ILLINOIS MEDICAL ASSISTANCE PROGRAM

(Must be Typed or Printed Legible and Do Not Use Highlighter On Any Documents.)

All fields must be completed or the application may be returned. If a field is Non-Applicable, the applicant should type or print NONE.

SECTION A: PROVIDER

1. New Enrollment Re-Enrollment Name Change Reinstatement Request 2. Provider Type

3. Provider Name

4. Primary Office Address

5. City 6. County

7. State 8. Zip Code 9. Telephone: 10. Fax:

11. E-mail Address (3)

12. National Provider Identification # - NPI **Report Additional NPI's In Section D** 13. FEIN

14. SSN 15. License/Certification 16. DEA

17. Medicare Part A# 18. Organization Type 19. Control of Facility 20. Fiscal Year

21. CLIA #

SECTION B: SERVICE/SPECIALTY

22. Category of Service

23. Provider Specialty: Primary Specialty Secondary Specialties

24. Physician UPIN No. 25. OBRA Qualifications (Physicians Only)

26. Hospital Admitting Privilege: (Physicians Only)

Hospital Name Address

Hospital Name Address

27. Pharmacy Location 28. Pharmacist In Charge 29. License #

30. Electronic Billing? Yes No 31. If Yes, Pharmacy Software Vendor Name 32. Pharmacy NCPDP#

33. Transportation: Taxi Base/Meter/Flag Rate 34. Taxi Mileage Rate 35. Medicar: Hydraulic Manual Lift or Ramp Yes No

36. Long Term Care Medical Bed Capacity 37. Long Term Care Medicare Fiscal Intermediary

38. Long Term Care Building ID Code

SECTION C: FORMER PARTICIPATION

39. Change of Ownership Yes No Effective Date

40. Former Provider Number Former Provider Name

SECTION D: ADDITIONAL NPI - National Provider Identification #

41. NPI NPI NPI

NPI NPI NPI

SECTION E: PAYEE INFORMATION

42. Name 43. Telephone:

44. DBA

45. Street Address

46. City 47. State 48. Zip Code 49. TIN Type Code

50. SSN/FEIN 51. Billing Provider/Pay To NPI #

52. Medicare Part B# 53. PIN 54. DMERC#

Name Telephone:

DBA

Street Address

City State Zip Code TIN Type Code

SSN/FEIN Billing Provider/Pay To NPI #

Medicare Part B# PIN DMERC#

SECTION F: CERTIFICATION/SIGNATURE

I understand that knowingly falsifying or willfully withholding information may be cause for the denial or termination of participation in the Medical Assistance Program and such conduct may be prosecuted under applicable Federal and State laws..

Under penalties of perjury, I hereby certify that all of the information provided in this application process is true, correct and complete and that the enrolling provider is in compliance with all applicable federal and state laws and regulations. I further certify that neither I, nor any of the following provider's employees, partners, officers, or shareholders owning at least five percent (5%) of said provider are currently barred, suspended, terminated, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from participation in the Medicaid or Medicare programs, nor are any of the above currently under sanction for, or serving a sentence for conviction of any Medicaid or Medicare program violations. I further certify that none of the above are currently sanctioned by any federal agency for any reason. I authorize the Department of Healthcare and Family Services, to verify the information provided on this application with other state and federal agencies. I further certify that I will review and comply with the Department's policies, rules and regulations including but not limited to those found at the following websites:

Illinois HFS website address: <http://www.hfs.illinois.gov/>
Illinois HFS Handbook updates are available: <http://www.hfs.illinois.gov/handbooks>
Illinois HFS Laws and Rule Regulations: <http://www.hfs.illinois.gov/lawsrules/index.html>

Check this box if you want a provider handbook mailed

Signature: Date

Printed name of person signing above

**ATTACHMENT A
DO NOT RETURN THIS PAGE**

PROVIDER TYPE/CATEGORY OF SERVICE TABLE

<u>PROVIDER TYPE</u>	<u>ALLOWABLE CATEGORY OF SERVICE</u>
10 Physicians	001 Physician Services
12 Optometrist	003 Optometric Services 045 Optical Supplies
22 Physical Therapists	011 Physical Therapy Service 041 Medical Equipment/Prosthetic Devices 048 Medical Supplies
23 Occupational Therapists	012 Occupational Therapy Services 041 Medical Equipment/Prosthetic Devices 048 Medical Supplies
24 Speech Therapists	013 Speech Therapy/Pathology Services 041 Medical Equipment/Prosthetic Devices 048 Medical Supplies
25 Audiologists	014 Audiology Services 041 Medical Equipment/Prosthetic Devices 048 Medical Supplies
55 Early Intervention	007 Developmental Therapy Services 031 Early Intervention Services 068 Service Coordination
63 Assistive Technology	041 Medical Equipment/Prosthetic Devices 048 Medical Supplies
71 Medicar	054 Service Car NOTE: For Provider Type 71 the only option for enrollment/payment will be Category of Service 054, Service Car.
72 Taxicab and Livery Companies	053 Taxicab Services 054 Service Car
73 Other Transport Providers (Non-registered)	055 Auto Transportation (Private) 056 Other Transportation
74 Hospital-Based Transport Providers	053 Taxicab Services 054 Service Car

NOTE: Provider Type 55, Category of Service 031 includes:

- Board Certified Behavior Analyst
- Registered Nurses
- Clinical Psychologists
- School Psychologists
- Clinical Professional Counselors
- Professional Counselors
- Clinical Social Workers
- Social Workers
- School Social Workers
- Marriage and Family Therapists

Illinois Department of Healthcare and Family Services

AGREEMENT FOR PARTICIPATION IN THE ILLINOIS MEDICAL ASSISTANCE PROGRAM FOR TRANSPORTATION PROVIDERS

WHEREAS, _____

_____ HFS Provider Number, if applicable) hereinafter referred to as ("the Provider") is enrolled with the Illinois Department of Healthcare and Family Services, hereinafter referred to as ("the Department"), as an eligible provider in the Medical Assistance Program; and

WHEREAS, the Provider wishes to submit claims for services rendered to eligible HFS clients;

NOW THEREFORE, the Parties agree as follows:

1. The Provider agrees, on a continuing basis, to comply with all current and future program billing and policy provisions as set forth in the applicable Department of HFS Medical Assistance Program rules and handbooks.
2. The Provider agrees, on a continuing basis, to comply with applicable licensing standards as contained in State laws or regulations.
3. The Provider agrees, on a continuing basis, to comply with Federal standards specified in Title XIX and XXI of the Social Security Act and with all other applicable Federal and State laws and regulations.
4. The Provider agrees that any rights, benefits and duties existing as a result of participation in the Medical Assistance Program shall not be assignable without the written consent of the Department.
5. The Provider shall receive payment based on the Department's reimbursement rate, which shall constitute payment in full. Any payments received by the Provider from other sources shall be shown as a credit and deducted from charges sent to the Department.
6. The Provider agrees to be fully liable for the truth, accuracy and completeness of all claims submitted electronically or on hard copy to the Department for payment. Provider acknowledges that it understands the laws and handbook provisions regarding transportation services and certifies that the services will be provided in compliance with such laws and handbook provisions. Provider further acknowledges that compliance with such laws and handbook provisions is a condition of payment for all claims submitted. Any submittal of false or fraudulent claim or claims or any concealment of a material fact may be prosecuted under applicable Federal and State laws.
7. The Provider agrees to furnish to the Department or its designee upon demand all records, associated with submitted claims necessary to disclose fully the nature and extent of services provided to individuals under the Medical Assistance Program and maintain said records for not less than three (3) years from the date of service to which it relates or for the time period required by applicable Federal and State laws, whichever is longer. The latest twelve months of records must be maintained on site. If a Department audit is initiated the Provider shall retain all original records until the audit is completed and every audit issue has been resolved, even if the retention period extends beyond the required period.

8. The Provider agrees that vehicle operator(s) shall have an appropriate Drivers License and vehicle(s) shall be properly registered and safely maintained in accordance with Department rules and handbook provisions.
9. The Provider agrees to comply with the Federal regulations requiring ownership and control disclosure found at 42 CFR Part 455, Subpart B.
10. The Provider agrees to exhaust all other sources of reimbursement prior to seeking reimbursement from the Department.
11. The Provider agrees to be fully liable to the Department for any overpayments, which may result from the Provider's submittal of billings to the Department. The Provider shall be responsible for promptly notifying the Department of any overpayments of which the Provider becomes aware. The Department shall recover any overpayments by setoff, crediting against future billings or by requiring direct repayment to the Department.
12. The Provider certifies that there has not been a prohibited transfer of ownership interest to or in the provider by a person who is terminated or barred from participation in the Medical Assistance Program pursuant to 305 ILCS 5/12 B 4.25.
13. The Provider certifies that the following is a complete list of owners/stock holders owning 5% or more of the stock/shares. If additional space is needed for names, please use separate page. If there is no information to disclose, write NONE on PRINT NAME line. This section MUST be completed for enrollment purposes and an entry is required.

_____ PRINT NAME	_____ SOCIAL SECURITY NUMBER	_____ % OF OWNERSHIP
_____ PRINT NAME	_____ SOCIAL SECURITY NUMBER	_____ % OF OWNERSHIP
_____ PRINT NAME	_____ SOCIAL SECURITY NUMBER	_____ % OF OWNERSHIP
_____ PRINT NAME	_____ SOCIAL SECURITY NUMBER	_____ % OF OWNERSHIP
_____ PRINT NAME	_____ SOCIAL SECURITY NUMBER	_____ % OF OWNERSHIP
_____ PRINT NAME	_____ SOCIAL SECURITY NUMBER	_____ % OF OWNERSHIP
_____ PRINT NAME	_____ SOCIAL SECURITY NUMBER	_____ % OF OWNERSHIP

14. The Provider agrees that every shareholder with 5% or more of the stock/shares, every partner in a partnership, the sole proprietor and each officer, manager and dispatcher shall submit to fingerprint based criminal background checks as provided in 89 Illinois Administrative Code Section 140.498.
15. The Provider certifies that the following is a complete list of every partner in a partnership, the sole proprietor and each officer, manager and dispatcher. If additional space is needed for names, please use separate page. This section MUST be completed for enrollment purposes and an entry is required.

_____ PRINT NAME	_____ SOCIAL SECURITY NUMBER	_____ POSITION WITHIN COMPANY
_____ PRINT NAME	_____ SOCIAL SECURITY NUMBER	_____ POSITION WITHIN COMPANY
_____ PRINT NAME	_____ SOCIAL SECURITY NUMBER	_____ POSITION WITHIN COMPANY
_____ PRINT NAME	_____ SOCIAL SECURITY NUMBER	_____ POSITION WITHIN COMPANY

16. The Provider agrees and understands that knowingly falsifying or willfully withholding information on the Provider Enrollment Application and/or the Agreement for Participation may be cause for termination of participation in the Illinois Medical Assistance Program and such conduct may be prosecuted under applicable Federal and State laws.
17. The Provider agrees and understands that enrollment of a non-emergency transportation vendor, as defined in 89 Illinois Administrative Code Section 140.13, shall be conditional for 180 days, during which time the Department may terminate such vendor's eligibility to participate in the Medical Assistance Program without cause. Such termination of eligibility is not subject to the Department's hearing process. Upon termination of the non-emergency transportation vendor, the following individuals shall be barred from participation in the Medical Assistance Program: individuals with management responsibility; all owners or partners in a partnership; an officer or individual owning, directly or indirectly, 5% or more of the shares of stock or other evidence of ownership in a corporation; or an owner of a sole proprietorship.
18. This agreement becomes effective the date the Department completes its review of the application for enrollment. No payment will be made for services rendered prior to the completion of the application's review. The provider certifies that all services will be rendered in compliance with and subject to the terms and conditions of this agreement.

Under penalties of perjury, the undersigned declares and certifies that the information provided in this Agreement for Participation is true, correct and complete.

ILLINOIS DEPARTMENT of
HEALTHCARE and FAMILY SERVICES:

by: _____
(Provider Signature)

by: _____
Division of Medical Programs

(Print Name of Signature above)

Date: _____

Date: _____



Rod R. Blagojevich, Governor
Barry S. Maram, Director

Illinois Department of Public Aid

201 South Grand Avenue East
Springfield, Illinois 62763-0001

Telephone: (217) 782-0538
TTY: (800) 526-5812

Dear Transportation Providers:

The enclosed enrollment application for the Illinois Medical Assistance Program has been designed for use by all providers with specific sections relating to different provider types. Please read the enclosed instructions prior to completing the forms.

Your enrollment request will be processed, upon completion and receipt of the enclosed: Medical Provider Enrollment Application (Form 2243) and Transportation Provider Agreement (Form 1413T).

Before your enrollment is approved, your application to become a Medicaid provider will be investigated by the Office of Inspector General. This may include an **on-site** physical inspection of your office, equipment, record keeping and other areas related to your operation.

Each provider is required to report the Name and Federal Employee Identification Number of the entity to whom payments are to be made on their behalf. Enclosed for your convenience is a Request for Taxpayer Identification Number and Certification Form (W-9) to be completed and returned with your enrollment request.

PLEASE NOTE: The DPA 1413T Transportation Provider Agreement requests names, social security number and percentage of ownership of owners/stock holders who own 5% or more of the stock/shares. If Not Applicable (NA), please so indicate.

The DPA 1413T Transportation Provider Agreement also requests names, social security number and position within the company of every partner in a partnership, the sole proprietor and each officer, manager, dispatcher and all individuals in charge of day to day operations.

ALL INDIVIDUALS THAT ARE LISTED ON THE DPA 1413T TRANSPORTATION PROVIDER AGREEMENT MAY HAVE TO SUBMIT TO A FINGERPRINT-BASED CRIMINAL BACKGROUND CHECK. SEE THE ATTACHED FORM ON CRIMINAL BACKGROUND CHECKS FOR MORE INFORMATION AND EXCLUSIONS FROM THIS RULE!

No enrollment will be effective until the Department approves the application. No service should be provided prior to notification of enrollment approval. **PAYMENT WILL NOT BE MADE FOR SERVICES RENDERED PRIOR TO THE EFFECTIVE DATE OF ENROLLMENT.** Change in ownership or corporate structure necessitating a new Federal Tax Identification Number terminates the participation of the enrolled provider. **PARTICIPATION IS NOT TRANSFERABLE.**

Once enrolled, a Provider Information Sheet will be mailed to the participating provider at both the office and payee location(s) listed on the enrollment application. The Provider Information Sheet is to be reviewed for accuracy and used as a reference in preparing claim forms. Reporting of discrepancies or changes to the information originally submitted to IDPA are to be noted on the Provider Information Sheet and mailed to the address below. An updated Provider Information Sheet will then be mailed to both the office and payee location(s).

A Provider Handbook of the specific rules and regulations relative to the type of service(s) you provide is available on the Internet. Handbooks on the Internet can be located at <http://www.dpaininois.com/handbooks/>

The Illinois Department of Public Aid appreciates your interest in enrolling in the Illinois Medical Assistance Program. If you have any questions regarding the completion of the enclosed forms, please call the Provider Participation Unit at (217) 782-0538. Otherwise, please return the completed forms to the address below.

**Illinois Department of Public Aid
Provider Participation Unit
P. O. Box 19114
Springfield, Illinois 62794-9114**

Criminal Background Check Information

Criminal background checks are required for all Non-Emergency Transportation (NET) Providers except the following: Ambulance providers (including helicopters), private automobiles and all NET providers that are owned or operated by governmental agencies.

The Non-Emergency Transportation Fingerprint Form (ORI: IL920600Z) must be completed by **each individual** listed on the DPA 1413T Transportation Agreement when submitting for the Criminal Background Check.

Timeframe for submitting fingerprints: All individuals identified must submit their fingerprints within thirty (30) days of the submission of a provider application.

Providers shall be responsible for the payment of the costs of fingerprint-based criminal background checks. Information regarding fees may be obtained from the respective Fingerprint Vendors.

The following is a list of the Fingerprint Vendors currently providing this service for the Illinois State Police.

Art's Investigations 409 W. Huron, Suite 500 Chicago, Illinois 60610 Phone 1-866-361-9944 Fax 312-932-0596 Website: www.artsinvestigations.com	Statewide Coverage	Identix Identification Services 1650 Wabash, Suite D Springfield, Illinois 62704 Phone 1-800-377-2080 Website: www.identix.com/iis/	Statewide Coverage
Digby's Detective & Security Agency Inc. 2630 South Wabash Avenue Chicago, Illinois 60616 Phone 312-326-1100 Email: fingerprint@digbysecurity.com	Regional Coverage	The Security Professionals, Inc. 5650 South Archer Avenue Chicago, Illinois 60638-1640 Phone 773-581-8181 Website: www.secproinc.com	Regional Coverage
Richardson & Associates 18503 Torrence Avenue Lansing, Illinois 60438 Phone 708-474-4900 Fax 708-474-3797 Website: www.richardson.webpointusa.com	Regional Coverage	Firm Inc. 206 South Sixth Street Springfield, Illinois 62701-9929 Phone 217-753-1190 Fax 217-525-1271 Website: www.verifyinc.com Contact: Bill Koeller Email: bkoeller@hso.net Contact: Michael Cheatham Email: mcheatham@hso.net	Statewide Coverage
Security Partners International, Inc. PO Box 5392 River Forest, Illinois 60305 Phone 1-877-774-7266 Fax 1-630-629-4916 Website: www.1877spgs.com	Regional Coverage		

Out of State Applicants: Individuals who reside outside the State of Illinois and do not have an opportunity to submit their fingerprints to one of the electronic fingerprint facilities specified above must submit fingerprint cards for the Illinois State Police and the FBI. The Department suggests that those NET provider applicants who must be fingerprinted contact a local police authority in their state of residence to obtain classifiable prints. **Fingerprint cards generally available at local police stations will not be accepted, nor will copies of cards!** Please send your request for the approved fingerprint cards to:

Illinois Department of Public Aid
Office of Inspector General /CVU
404 North 5th Street
Springfield, Illinois 62702
217-524-8414



ENROLLMENT DISCLOSURE STATEMENT ILLINOIS MEDICAL ASSISTANCE PROGRAM

1. Identifying Information

Provider Name	DBA Name	Provider No.	NPI
---------------	----------	--------------	-----

Provider Office Street Address

City, County, State	Zip Code	Telephone ()
---------------------	----------	----------------------

2. (a) List the name, address, and SSN/EIN of each person and/or entity with direct or indirect ownership or control interest in the disclosing entity or any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. List any additional names, addresses, and SSN/EIN under "Remarks" on page 2.

Name	Address	SSN/EIN

(b) If any persons listed in 2(a) are related to each other as spouse, parent, child, sibling, grandparent, grandchild, uncle, aunt, niece, nephew, cousin or relative by marriage, list that relationship (i.e. John Smith and Mary White are siblings).

(c) Check type of entity: Sole Proprietorship Partnership Corporation Unincorporated Associations
 Other, please specify _____

List the name, address, and SSN of the Directors, Officers, Partners, and Managing Employees of the Disclosing Entity. List any additional names, addresses, and SSN under "Remarks" on page 2.

Name	Address	SSN

(d) Are any of the individuals/entities listed in 2(a) also current or previous owners of other Medicare/Medicaid entities?

Yes No If yes, for each affiliation list the individual/entity name from 2(a); the name, address, and provider number of the affiliated entity, along with the affiliation date. List any additional information as needed under "Remarks" on page 2.

Individual/Entity (2(a))	Name of Affiliated Entity	Affiliated Entity's Address	Affiliated Entity's Provider Number	Date of Affiliation

ENROLLMENT DISCLOSURE STATEMENT

3. Has there been a change in ownership or control for the disclosing entity within the last year? Yes No

If yes, give date and name of prior owner(s) _____

If the prior owner is a relative of anyone listed in 2(a), state the individual from 2(a) and the relationship (spouse, parent, child, sibling, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage).

4. List any person who: (1) Has ownership or control interest in the disclosing entity, or is an agent, or managing employee of the disclosing entity; and (2) Has been convicted of a criminal offense:

Name	Ownership Interest/Position	Criminal Offense	Date

5. List any person who: (1) Has ownership or control interest in the disclosing entity, or is an agent, or managing employee of the disclosing entity; and (2) Has been sanctioned (previously or currently) by any health care related program including, but not limited to, Medicare, Medicaid, or the Title XX services program since the inception of those Programs.

Name	Sanction	Date	State

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT WITH THE DEPARTMENT.

Name of Authorized Representative (Typed)

Title

Signature

Date

Remarks:

Request for Taxpayer Identification Number and Certification

**Give Form to the
requester. Do not
send to the IRS.**

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification (required): <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate	
	<input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶	
	<input type="checkbox"/> Other (see instructions) ▶	
Address (number, street, and apt. or suite no.)		Requester's name and address (optional)
City, state, and ZIP code		
List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number									
				-			-		

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Employer identification number									
				-					

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,
- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a “saving clause.” Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called “backup withholding.” Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the “Name” line. You may enter your business, trade, or “doing business as (DBA)” name on the “Business name/disregarded entity name” line.

Partnership, C Corporation, or S Corporation. Enter the entity's name on the “Name” line and any business, trade, or “doing business as (DBA) name” on the “Business name/disregarded entity name” line.

Disregarded entity. Enter the owner's name on the “Name” line. The name of the entity entered on the “Name” line should never be a disregarded entity. The name on the “Name” line must be the name shown on the income tax return on which the income will be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a domestic owner, the domestic owner's name is required to be provided on the “Name” line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the “Business name/disregarded entity name” line. If the owner of the disregarded entity is a foreign person, you must complete an appropriate Form W-8.

Note. Check the appropriate box for the federal tax classification of the person whose name is entered on the “Name” line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

Limited Liability Company (LLC). If the person identified on the “Name” line is an LLC, check the “Limited liability company” box only and enter the appropriate code for the tax classification in the space provided. If you are an LLC that is treated as a partnership for federal tax purposes, enter “P” for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter “C” for C corporation or “S” for S corporation. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the “Name” line) is another LLC that is not disregarded for federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the “Name” line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name/disregarded entity name" line.

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the "Business name/disregarded entity name," sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
 2. The United States or any of its agencies or instrumentalities,
 3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
 4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
 5. An international organization or any of its agencies or instrumentalities.
- Other payees that may be exempt from backup withholding include:
6. A corporation,
 7. A foreign central bank of issue,
 8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
 9. A futures commission merchant registered with the Commodity Futures Trading Commission,
 10. A real estate investment trust,
 11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
 12. A common trust fund operated by a bank under section 584(a),
 13. A financial institution,
 14. A middleman known in the investment community as a nominee or custodian, or
 15. A trust exempt from tax under section 664 or described in section 4947.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 5 and 7 through 13. Also, C corporations.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 7 ²

¹ See Form 1099-MISC, Miscellaneous Income, and its instructions.

² However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at www.ssa.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, below, and items 4 and 5 on page 4 indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt Payee* on page 3.

Signature requirements. Complete the certification as indicated in items 1 through 3, below, and items 4 and 5 on page 4.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee ¹ The actual owner ¹
5. Sole proprietorship or disregarded entity owned by an individual	The owner ³
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	Give name and EIN of:
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity ⁴
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))	The trust

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name and you may also enter your business or "DBA" name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

*Note. Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: spam@uce.gov or contact them at www.ftc.gov/idtheft or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.